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ABSTRACT

Traditionally, the elderly have not been viewed as appropriate candidates for dynamic psychotherapy. To examine the effectiveness of a psycho-dynamically oriented group (focusing on the issues of aging, conflict resolution, and self-actualization) on 6 older adult participants, ages 63 to 87 years, systematic clinical observations of group participation, medical facility relationship, and real life situations were made. All members were screened for intact cognitive functioning; however, all members were suffering from a variety of psycho-social as well as physical stressors. Common themes of the group were death, dependency needs, depression and loss of control, loneliness, pride in survival and accomplishments, and health problems relating to the aging process. Insight-oriented techniques (literature review, role play) in conjunction with support and elements of socialization (networking) were used to facilitate the therapy. Measures of success of the group were regular attendance, decreased requests for medication, increased socialization and independent activity, and increased abilities to communicate and discuss sensitive issues. A concomitant improvement in problem-solving abilities was also noted. The findings suggest that group therapy is a viable and beneficial treatment modality for older adults. (Author/BL)

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EXPRESSIVE GROUP PSYCHOTHERAPY WITH THE OLDER ADULT

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ABSTRACT

Traditionally, the elderly have not been viewed as appropriate candidates for dynamic psychotherapy. We have been conducting a psychodynamically oriented group with six older adults ranging from 63 to 87 years of age during the past two years. All members were screened for intact cognitive functioning; however, all members were suffering from a variety of psycho-social as well as physical stressors. Common themes of the group were death, dependency needs, depression and loss of control, loneliness, pride in survival and accomplishments, as well as health problems relating to the aging process. Measures of success of the group have included regular attendance, decreased requests for medication, increased socialization and independent activity, and increased abilities to communicate and discuss sensitive issues. There was also a concomitant improvement in problem-solving abilities. We conclude that group therapy is a viable and beneficial treatment modality for the older adult and facilitates his ability to work on important aspects of age-specific developmental tasks. Benefits include improvement in the quality of life of the older adult and positive growth experiences for the therapist and patient alike.

Key Words: Dynamic, Aging, Treatment Modality

Traditionally, the elderly are not viewed as appropriate candidates for dynamic psychotherapy.

Freud [1905 (1904)] reflected old people are no longer flexible in their mental processes and therefore not candidates for psychotherapy, thus confirming the "ageism" biases of many therapists. Sparacino (1978-79) noted barriers on the part of the therapist and the patient alike: Therapists often have a lack of geropsychiatric training, negative attitudes toward aging, possible fear of therapeutic failure, preference for younger clients and limited medicare reimbursement.

The Group for the Advancement of Psychotherapy Report (1971) gave reasons for negative attitudes among therapists as follows:

1. The aged stimulate the therapist's fears about his* own aging and death.

2. The elderly arouse the therapist's conflicts about his relationship with parental figures.

3. The older adult may die while in treatment, which could challenge the therapist's sense of importance.

4. The therapist may believe his skills may be wasted with the aged, because the aged are near death and not really deserving of attention.

Patient-related barriers were identified as: tolerance of psychopathology, acceptance of psychologic problems as a normal part of aging, negative attitudes toward psychiatry, therapy seen as a sign of weakness, transportation and financial limitations.

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*The pronoun "he" will be used to note "he/she."

However, Goldfarb (1954) found that verbal group psychotherapy with the older patient, aimed at realistic appraisal of strengths and limitations, was not only possible but definitely therapeutic.

Berland and Poggi (1979) noted that the elderly desire and are able to confront issues of the life stage and do so with insight, energy and benefit. Butler (1963) indicated therapy is surprisingly successful because the elderly are aware their time is limited and their problems are imminent.

The literature has suggested a variety of group therapy modes that are rehabilitative in nature; i.e., reality orientation, remotivation, resocialization, or problem-oriented (stroke recovery, widowhood). Little group work has been documented that expressly works on the issues of aging, conflict resolution and self-actualization.

The group was begun with the premise that older adults can extend and grow; with this growth they often will resolve some of their less-ingrained personality problems.

This group was conducted by an M.S.W./Nurse Clinician at a University Mental Health Center that has a Geropsychiatry Unit. The fee for the group was $25 per session.

GROUP SELECTION

Member selection was based on the following criteria: Cognitively intact patients with absence of psychosis. Participants were referred by their psychiatrist who continued his relationship with them.

Prospective members were interviewed to evaluate them for cognitive

verbal skills, psychological mindedness and a common motivation to participate. Members were expected to attend weekly, arrange own transportation and were responsible for calling if unable to attend.

Pfeiffer's (1975) short portable mental status questionnaire was used to screen for gross deficits. Group therapy goals and process were explained and a handout (Table 1) specifying the group goals and process was given to participants.

Members' expectation of the group experience was one of uncertainty, of what group therapy was and what would happen to them. This uncertainty paralleled their concern with their purpose in living.

Problems frequently encountered were loss of spouse, rejection and loss of family, loss of physical health and stamina.

We defined for ourselves the goals of group as:

1. Enhance communication skills by encouraging verbalization of thoughts, feelings and by contrasting opinions without fear of rejection.

2. Become aware of and discuss previously denied or repressed areas of conflict, thus helping self and others to resolve them.

3. Identify and work on behaviors of areas of concern that impede or affect abilities to function in everyday situations.

4. Increase abilities to share with one another and provide opportunities to develop these skills.

5. Increase self-esteem by involvement in group processes accenting feelings of personal worth, usefulness and competency.

TABLE 1 — GROUP THERAPY HANDOUT

GROUP THERAPY

Participants in similar situations can receive benefit from one another as well as the therapist. The aim is looking into personal and interpersonal problems.

Problem sharing is a part of group work as well as social support (develop new friendships and social skills).

THE FOCUS IS ON SEVEN AREAS	BENEFITS RECEIVED FROM GROUP
1. Real-life, day-to-day problem.	1. You will see that many others have similar concerns and that you are not alone.
2. Sharing of relevant experiences.	2. You will see that sharing experiences can help you solve problems, look at past ways of coping and look at situations that cause you distress.
3. Learning to listen and thus becoming more sensitive to the needs and feelings of others.	3. While you listen, you will be gratified to know that others will listen to you. You can become aware of how you come across to people.

4. Offering new or different perspectives on situations being discussed.
5. Asking questions.
6. Expressing differing opinions without fear of criticism.
7. Keeping a topic in focus until a conclusion is reached.

4. Added dividend — others offer solutions, then you can choose what you like.
5. Group will try to give answers.
6. You can build your own courage; sometimes you will be criticized, but you can take it.
7. When you have a problem, you can look at it and try to solve it in a logical way.

6. Increase insight into the social impact of one's behavior on self and others.

7. Increase self-acceptance, including acceptance of one's own affect.

GROUP COMPOSITION

Ten potential participants were referred by the geropsychiatrists. Suitable and motivated participants were interviewed for membership. The initial group comprised two males and four females ranging from 63 to 67 years. The group was an open, ongoing assemblage in which members would be added as dropouts occurred. Depressive adjustment reaction secondary to socio-environmental losses, i.e., death of a spouse, moves and retirement, was the primary diagnosis. Two had additional diagnosis of Compulsive Personality. Physical disorders included chronic respiratory problems, cardiovascular disease, musculoskeletal problems, degenerative eye disease and chronic pain secondary to multiple physical conditions. Four candidates were dropped for: lack of interest (2), lack of commitment (1) and physical illness (1). Three participants had received inpatient psychiatric treatment prior to referral to group. Current drugs included anxiolytics (2), antidepressants (3), combination of anxiolytics plus antidepressants (1). In addition, one patient was taking a prescription analgesic.

The usual attendance was four to five members. Illness, transportation difficulties or inclement weather were the main reasons for absences.

Currently, four additional members, all female, have been included. Depression remained the primary diagnosis. Three had prior hospitalization

for treatment; one with a successful course of electroconvulsive therapy. The physical disorders included Parkinson's Disease, arthritis and colitis. Three received antidepressant medication and one received no medication.

PROCEDURE

As one might expect, the group got off to a slow start. As noted by Yalom (1975), they began by searching for similar ties, gave advice and tried to please the therapist.

They spent many sessions establishing trust of one another and of the therapist. This issue recurred many times, particularly when new members were added. Communication was restrictive and cautious; with little push toward revelation or autonomy. Group posture was one of fear of rejection and not wanting to burden others with their problems.

Older patients like younger ones relied on the therapist for directions and feedback (Yalom, 1975). The therapist, therefore, assumed an active support stance, interpreting here and now, group as a whole, individual and transference issues. For example, members made global statements, "I'm nuts/crazy." Therapist redirected these generalized statements back to the group and tried to elicit personal experiences. Other global concerns voiced were: violent crime toward the elderly, children's duties to parents and welfare abuse. The evocative and interpretive response of the the therapist, exposing the latent themes of rage, greed, and thwarted dependency, encouraged individuals who were reticient about discussing conflicts and feeling level issues. The acitve role of the therapist became a model for members to imitate until trust and group experience evolved.

ONGOING PROGRESS

Communication style was with participant-to-therapist with less interaction member-to-member. As the group became more cohesive, members' interactions increased with less dependence on therapist for approval and direction. Group has expanded from the original six members. New members have been incorporated with minimal disruption. Original members all resided in community settings, i.e., own home, with a relative or in a Senior Citizen congregate apartment. Recently, a nursing home resident was added to the group. This individual has added another dimension to the group experience for older adults. First, it provided experiential input of what the nursing home is really like. More importantly, it opened a new opportunity for group work with the cognitively intact older adult living in an extended care facility and allowed that individual outside stimulation. Overall, the group experience has provided an atmosphere of trust and acceptance, growth and redirection and has been positive for therapist and members.

AGE RELEVANT THEMES

Common themes of the group were death, dependency versus independency, depression and loss of control over their lives. Other related themes were loneliness, hopelessness, pride in survival and in their accomplishments, rejection by and of family and others; courage, obedience, health problems and aging and relations with health care (medical) personnel.

TECHNICAL ADAPTATION

The difference between traditional psychodynamic groups and this one is

in the use of a combination of treatment approaches. The therapist used insight-oriented techniques in conjunction with support and elements of socialization. Group moved in and out of these three modalities. Discussion of networking among the members was initiated by the group members with implicit acceptance by the therapist. As the members became more confident, a variety of activities and networks emerged, i.e., phone check system, relaying of community older adults' events and encouraging others to attempt new activities.

Creative approaches were tried to redirect to "here and now" issues. For example, use of photographs to stimulate discussion of the relation of past to present. Other techniques such as role play, videotaping and playback, and poems about aging and death were incorporated.

Videotaping and review were suggested early in the group. After much discussion, the idea was dropped. There was much resistance to this idea with threats of refusal to participate. Only one member saw the benefit of observing her own and others' behavior. A year later, videotaping was again introduced and accepted with much enthusiasm. The participants who had objected are still present, but they are less defensive and the group is more cohesive and able to take more risks now. The option of a leaderless group was introduced when the leader went on vacation. In the early stages of the group, this idea was rejected and group was cancelled while the leader was on vacation. The members responded to the leader's absence by not attending group upon her return, punishing her for abandoning them. About a year later, the option again was introduced; the group took the risk

and had sessions without the leader. They reported that it was supportive and social; moreover, they felt it was beneficial because it encouraged them to be more assertive and not to depend on the leader for direction.

The therapist utilized life review or reminiscence as a psychotherapeutic tool to assist group members in understanding, resolving present and past conflicts. Butler (1963) recognized reminiscence as a positive feature of reintegration. (1) Life review is used to identify and utilize past coping mechanisms to apply to present-day problems; (2) to re-identify past success as a model for present attempts; and (3) to confront conflicts and anxieties about death, guilt, etc.

PROBLEMS

As with any new attempt, there were problems, one of which was anxiety of the leader, inexperienced in working with groups. This was a challenging experience for the therapist. The therapist brought to the group her energy and motivation for a successufl experience.

An experienced group therapist provided supervision on a weekly basis. Working with the elderly population was a new venture for both. At times the unrealistic goals of the therapist had to be reviewed, i.e., wanting a more ambitious insight-oriented group. Handling of difficult group roles such as the monopolizer or the silent member evoked understanding, patience and skill. Such behavior, while not always a manifestation of resistance, could not be accepted regularly as inevitable and impersonal. This called for discrimination, exploration and tact.

There were practical problems, particularly relevant for patients of

this age group. For instance, attendance was a issue for therapist and members. Inclement weather was very disruptive. Members who became ill and were absent for several weeks often felt embarrassed and guilty about returning to group and needed support and follow-up by staff. Additionally, costs of group therapy sessions posed a problem for the elderly. Insurance and medicare covered most of the charges. Most members had to assume some financial responsibility for costs.

Another concern for therapist and supervisor in working with this population was confronting one's own aging and death. At times, therapist was attacked by group for "lack of age." Group members and therapist alike were cautious considering discussion of inevitability of death and/or continuing illness. To introduce the topic, they chose to use displacement by discussing deaths of pets or close relatives. When appropriate, the leader moved from displacement to more personal and poignant experiences.

EVALUATION

The group has been in progress for two years. Observation of the following benefits are:

A. During Group Sessions

-- There has been regular attendance for the past year and a half.

-- Increased self-esteem as voiced by members.

-- Increased abilities to communicate, take risks and discuss sensitive issues.

-- Increased insightfulness and problem-solving abilities.

-- More communication among members and less with therpaist.

B. **In Relationship to Medical Facility**

-- Few, if any, phone calls to office for assistance or problems.

-- Decreased requests for medication.

-- Improvement noted by other staff.

C. **In Real Life**

— Increased socialization and independent activities.

-- Increased networking and development of support systems.

-- Specific changes in living situations.

Two members required re-hospitalization. Therapy was briefly interrupted for one member who unsuccessfully sought relief of his chronic pain, arthritis, obesity and dependency elsewhere. For the other one, it was not interrupted while she entered the hospital for relief from pressure created by disorganized son and daughter who temporarily moved in with her. The admissions were not viewed as a failure of the group therapy experience. As the group progresses, the goal would be to decrease the need for hospitalization by assisting these patients in developing more adaptive coping mechanisms.

DISCUSSION

Group therapy is a viable and beneficial treatment modality for the older adult. The advantage of a flexible approach outweighs any sacrifice of "theoretical purity." Older adults are at a stage of development that has a common set of themes and tasks. It is our belief that group therapy with the older adult can and does facilitate their ability to work on important aspects of age-specific developmental tasks. These benefits

include improvement in the quality of life of the older adult and positive growth experiences for the therapist and patient alike.

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